CUMULATIVE HEALTH RECORDS GUIDELINES

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CUMULATIVE HEALTH RECORDS GUIDELINES

Revised October 2002 by School Health Records Committee

Objective

The purpose of these guidelines is to promote consistent documentation on the Connecticut state-mandated Cumulative Health Record (CHR- 1) throughout school districts in the state.

School Health Record

The Cumulative Health Record serves as the official student health record within Connecticut schools. As such, it is recognized as a legal document. It provides a systematic way to organize the collection of health information and document health services provided to an individual student.

Black ink will be used for all documentation.
Red ink will be used exclusively when documenting allergies.
No other notation, no flagging or any other color coding shall be used.
Note: Classroom designation, if used, should be placed in pencil on the upper right-hand corner of the index tab.

The front of the CHR-1 was formatted to include all information needed for a student to enter a new school. This can be copied to provide the receiving school with all the necessary information for entry. The *student's name* needs to be printed clearly in *all four* designated areas.

Identifying Information

Student's Name	*Print* student's name clearly (last, first, middle).
Sex	Identify by circling M-male F-female Note: Not always apparent from the first name.
Birth Date	State in numbers (e.g., 3-6-87)
Address	Do not use the last line for identifying information. When additional space is needed, note "continuation" on the last line **or** check the box marked "continuation" on the last line. Photocopy appropriate continuation form. On photocopy, write name, sex, birth date and page number in the designated areas, continue documentation and place inside CHR - 1.
Phone Numbers	All phone numbers are to be written in pencil. Be sure to erase previous or out-of-order phone numbers.
Entry/Exit Dates	Self-explanatory. Dates are important and should be documented when a student enters and exits a school.
School Name/Town	School name and town must be completed and updated as needed.
Father/Mother/ Guardian's Name	Complete full names including last and first names. If the guardian is named, "guardian" should be circled. If the mother /father/guardian is deceased, please note.

Section I – Immunization Record

Dates must be accurate and clearly documented in numbers: month/day/year (e.g., 8/5/96). Record each immunization according to the specific immunization administered. Various vaccine preparations are available, including those listed below.

DTP	Diphtheria, Tetanus, Pertussis
DTP/Hib	Diphtheria, Tetanus, Pertussis and Hemophilus combination vaccine
DtaP	Diphtheria, Tetanus, Acellular Pertussis
DT/Td	Diphtheria, Tetanus
OPV	Oral Polio
IPV	Inactivated Polio
MMR	Measles, Mumps, Rubella-combination
Measles	Document here only when single valent vaccine is used
Mumps	Document here only when single valent vaccine is used
Rubella	Document here only when single valent vaccine is used
HIB	Hemophilus Influenza B
HBV	Hepatitis B
Varicella	Chicken Pox

For **"Other Vaccines,"** complete section with the name and date (e.g., Pneumovax 10/2/90).
Tuberculin tests are recorded in Section II, not in this section.

The **disease history** line can be used for the following communicable diseases: measles, mumps, rubella, diphtheria, tetanus, polio, hepatitis and chicken pox.

Documentation of disease history or immunity must be confirmed by a blood titer. The name of the provider who has interpreted the blood titer must also be recorded. In Section I on the line, "Disease Hx of the above, Specify," identify the disease (e.g., measles). On the date line, place the date of the titer, and on the line "confirmed by," place the name of the provider who interpreted the titer.

Exception: Chicken pox can be documented here but needs either confirmation by a blood titer or documentation of the disease in writing by an MD, APRN or physician's assistant.

Exemptions:

Religious exemption remains in effect until the parent/guardian gives written notice of change. Enter date of written notification on the line next to "Religious".

When a child has a medical exemption, the underlying issue can be permanent in nature (e.g., egg anaphylaxis) or temporary in nature (e.g., student or sibling undergoing chemotherapy). **Temporary exemptions must be renewed in writing yearly**. Significant Medical Information, Section III, and/or Nurse's Notes can be used if more clarification is required.

Section II – Mandated Health Assessments

This section refers to state-mandated health assessments. In Connecticut, these include health assessments prior to public school entrance, in Grade 6 or 7, and in 10 or 11 (the specific grade is determined by the local or regional board of education).

Mandated assessments are also required for students in ungraded classrooms at an age-appropriate time, and for students in private approved special education schools. Specific grade level is determined by the local board of education or governing boards within times permitted by statute.

Any other health assessments received other than those that are state mandated should be documented in Section IV- Additional Health Assessments. Be sure to document school year and grade. Transcribe information accurately and legibly.

Please Note: If lead and tuberculin screenings are noted on the health assessment, they must be documented on the CHR-1

Section III – Significant Medical Information

The objective of this section is to assist the receiving school to plan a safe and appropriate educational program for the student. Information listed should be dated and brief. Further clarification and investigation may be needed depending on the type of information included.

Medical Diagnosis includes any medical information that is likely to have a significant impact on the student (e.g., diabetes, seizures, severe asthma, depression, ADD, etc.). Include *life-threatening* allergies, which should be noted in *red* ink. According to CGS 19a-583, HIV/AIDS information cannot be recorded on the CHR. (Please note: any correspondence regarding the HIV/AIDS status of a student without proper consent should be returned to the sender).

Functional Concerns include any activity of daily living which is impaired or limited (e.g., wheelchair use, severe visual or hearing impairment).

Medications/Technology should be noted if they are administered or used during school hours, on a daily or PRN basis. Do not list medications by name; instead, note: 2/4/97 Received medication daily. List any procedures done in school (e.g., 2/4/97 Catheterization daily). Also include any devices used by the student (e.g., venous access, pacemakers, shunt, etc.).

Section IV – Screening Results

This section refers to screenings done in the school or performed as part of the mandated health assessments. Document accurately; grade/school year (if no grade applicable, enter school year only), date and results of each screening.

Vision Screening	will include a numerical value (e.g., 20/20). Document glasses/contacts next to the * of the current year.
Color Vision	if done, will be recorded as P-pass or F-failure.
Auditory	puretone and impedance, if done, will be recorded as P-pass or F-failure.
Postural	circle the appropriate result.
Other (Specify)	can refer to cholesterol, sickle cell or any other screenings that are required by the local board of education or received from the student's health care provider.

Any screening failure which leads to a referral needs to be documented in Section V.

Section V – Referral Information

Problem should refer to the failed screening.

Date Sent/Returned should be stated in numbers (e.g., 2/6/86).

Follow-up Summary – be brief and indicate results of the referral (e.g., glasses – f/u 1 year or provide date and record "see nurse's notes" for detailed information).
When additional space is needed for referral documentation, use nurse's notes.

Section VI – Additional Health Assessments

This section refers to any health assessment received other than those mandated by the state.
Refer to Section II.

Under type of assessment** use: S – to indicate a sports assessment
H – to indicate a health assessment

Section VII – Medications

Only medications *given in school* should be listed in this section. Note any significant medications administered outside of school hours in the nurse's notes.

Upon receipt of medication order, the start date, medication, dose, route, frequency and authorizing prescriber should be documented. Comments at this time should be limited to unusual circumstances (e.g., tegretol given for behavior). With discontinuation of the medication or annually at the end of the school year, document the stop date and comments regarding the course of the medication administration (e.g., good compliance, refuses medication periodically).

When additional space is needed, note "continuation" on the last line **or** check the box marked "continuation" on the last line. Photocopy appropriate continuation form. On photocopy write name, sex, birth date and page number in the designated areas, continue documentation and place inside the CHR-1.

Section VIII – Treatments

Only treatments *given in school* should be listed in this section. Note any significant treatments administered outside of school hours in the nurse's notes.

Upon receipt of treatment order, the start date, treatment, frequency and authorizing prescriber should be documented. Comments at this time should be limited to unusual circumstances (e.g., report signs of infection to parent/health care provider). With discontinuation of the treatment or annually at the end of the school year, document the stop date and comments regarding the course of the treatment (e.g., "procedure tolerated well" or " independent in self-care except for …").

When additional space is needed, note "continuation" on the last line **or** check the box marked "continuation" on the last line. Photocopy appropriate continuation form. On photocopy write name, sex, birth date and page number in the designated areas, continue documentation and place inside the CHR-1.

Section IX – Nurse's Notes

Nurse's Notes should be used to document pertinent health assessment data (e.g., daily visits, DCF referral, hospitalizations, serious injuries, yearly or exit summaries) and for information previously referred to in these guidelines. This section should include documentation of receipt of third party reports. If a health assessment summary for determination of special education eligibility is completed, it should be noted on the CHR.

When additional space is needed, note "continuation" on the last line **or** check the box marked "continuation" on the last line. Photocopy appropriate continuation form. On photocopy write name, sex, birth date and page number in the designated areas, continue documentation and place inside the CHR-1.

When electronic health records are used for documentation of school health services for individual students, the records should include all of the data requirements of the CHR. Such electronic record shall be printed and permanently affixed to the CHR.

Guidelines for Transferring Cumulative Health Information

The purpose of this section is to promote consistent procedures between school districts in managing and transferring health information in the Cumulative Health Record (CHR).

Section 10-206 (d) of the Connecticut General Statutes (CGS) indicates that when a student transfers to another school district in Connecticut, the original CHR is sent to the new school and a true copy is retained. For a student leaving Connecticut, a copy of the records, if requested, should be sent and the original maintained (i.e., the most recent health assessment and immunization record). The CHR, under this statute, is sent to the chief administrative officer of the school district. However, for protection of confidential student health information, the chief administrative officer could designate that the information be sent from nursing personnel to nursing personnel.

The Family Education Rights and Privacy Act (FERPA) allows for the transfer of records to the next educational institution without parental consent if the parents have been be given reasonable notice either through the annual notice or prior to forwarding the record and the option to request a copy of the record to be transferred.

School Definitions

Charter Schools – A charter school is a public nonsectarian school organized as a nonprofit corporation and operated independently of a local or regional board of education. Charter schools are authorized by the State Board of Education and are funded by the state. School health records are maintained in the same fashion as any local or regional public school.

Interdistrict Magnet Schools – A magnet school is a publicly funded school operated by a local or regional school district, by a regional educational service center or by cooperative agreement involving two or more districts. School health records are maintained by the owner of the magnet school.

Regional Educational Service Centers (RESC) – A RESC, which provides contracted programs and services to local and regional boards of education, is viewed as an extension of the local school district; therefore, the health record would be returned to the local school district.

Same Health Services – Nurses and others who provide same health services to private, nonpublic schools pursuant to § 10-217a of the CGS should maintain records in the same fashion as the local or regional public school.

Cumulative Health Record (CHR) – The CHR serves as the official student health record in Connecticut schools. As such, it is recognized as a formal part of an educational record and must be maintained as such. It provides a systematic way to organize the collection of student health information.

Guidelines for Transferring Cumulative Health Information*

Contents of the CHR that should be sent to new district:

- All HAR-3 forms (Health Assessment Record)
- All Early Childhood Health Assessment Record forms (ED 191)
- All Yearly Sports Physical Exams and Interim Health Histories for sports
- All Original Medication Orders including parental/guardian authorization
- Individual Medication Administration Sheets (including Controlled Substance Medication Administration Sheets) unless summarized on CHR
- All Special Health Care Procedure Orders, including parental/guardian authorization
- Special Health Care Procedure Logs or Flow sheets unless summarized on CHR
- All Mandated Screening Referrals and Follow-up Health Care Provider Reports
- Follow-up Health Care Provider Evaluations
- Summary of Nursing Health Assessments of students with disabilities
- Current Individualized Health Care Plan (IHCP) and Emergency Care Plan (ECP)
- Nursing Documentation, i.e., progress notes, episodic daily health room visits unless summarized on CHR
- DCF W-136 form, if district policy permits
- 504 Accommodation Plan
- Developmental/Health Histories, i.e., basic school entry, mandated health histories
- Specific Health Information Questionnaires, i.e., asthma, allergy, diabetes

Information that Remains in District:

- Access Sheets
- Third-party records
- Release of information forms
- Previous IHCP and ECP
- Miscellaneous Health Care Provider and Parent Notes
- Past Health Information Questionnaires

Information Not to Be Kept in CHR

- Accident/Incident Reports
- Raw Data from Nursing Assessments of students with disabilities
- Controlled Substance Medication Records
- Sole Possession Notes

* The following pages contain descriptions of the forms and additional information to clarify the guidelines.

Contents of the CHR

The following forms should be included in the CHR and should follow the student in the event of a school transfer:

HAR-3 (Health Assessment Record), including school entrance, Grade 6/7 and Grade 10/11, means Health Assessment Record, a form supplied by the State Department of Education per CGS, Section 10-206(d), commonly referred to as the "blue form."

Connecticut Early Childhood Health Assessment Record (ED 191) means the Health Assessment Record for children in any early childhood programs, commonly referred to as the "yellow form."

Yearly sports physical exams and interim health histories for sports means yearly physical assessments required by the Connecticut Interscholastic Athletic Conference (CIAC) or local district in order for students to participate in sports.

Medication orders (all original orders) to include parent/guardian authorizations means the authorization by an authorized prescriber for the administration of medication to a student during school activities for the current school year. The authorization must be renewed each school year. Authorized prescriber means a physician, dentist, advanced practice registered nurse or physician's assistant. Physician means a doctor of medicine or osteopathy licensed to practice medicine in Connecticut in accordance with Chapters 370-371 of the CGS, or licensed to practice medicine in another state.

Individual Medication Administration Sheets (including Controlled Substance Medication Administration Sheets) are to be included in the CHR until summarized on the CHR in the section titled "Medications." If the summary is not done, then these sheets must be kept in the CHR for 6 years following the student leaving the district. A separate record for controlled substances is also required for auditing purposes. These records, *Controlled Substance Medication Records*, are described below.

Special Health Care Procedure Orders (all original orders) to include parent/guardian authorization means the authorization by an authorized prescriber for special procedures (or treatments) to a student during school activities for no longer than the current school year. The authorization must be renewed each school year.

Special Health Care Procedure logs or flow sheets are to be included in the CHR until summarized on the CHR in the section titled "Treatments." If summary is not done, then these sheets must be kept in the CHR for 6 years following the student leaving the district.

Mandated vision, hearing and scoliosis screening referrals/health care provider reports means all mandated screening referral forms including the health care provider's follow-up report.

Follow-up Health Care Provider Evaluations means any follow-up evaluations or reports related to a student health referral made by the school nurse (e.g., one time episode of illness or injury, etc.).

Summary of nursing health assessment of students with disabilities means the summary of the most recent collection and analysis of a student's health needs or data relevant to their educational needs. This summary is used to plan intervention and accommodation referrals and collaborate with others to promote student's health and learning.

Current Individualized Health Care Plan (IHCP)/Emergency Care Plan (ECP)

- IHCP is the application and formalization of the nursing process in the school setting. An IHCP should include information about the student's needs, nursing interventions designed to meet those needs, and a description of how this care supports the educational process of the student.
- ECP is the procedural guidelines indicating whom to call and other information to be used when a predictable emergency occurs.

Nursing Documentation, e.g., progress notes, episodic daily health room visits, means documentation on individual student health room visits including assessment data, significant findings and nursing intervention and outcomes. All original nursing notes are to be included in the CHR unless a summary is documented on the CHR. This summary should include any pertinent health data which has occurred during the year.

DCF W-136 (to be included if district policy permits). Regardless of where the form is stored, a notation should be made on the CHR. This notation should include the date of the referral, the nursing assessment if conducted, and any relevant follow-up to ensure the safety and protection of the student.

504 Accommodation Plan means accommodation plan developed by the district, pursuant to Section 504 of the Rehabilitation Act of 1973, to meet the student's needs.

Developmental/health histories, i.e., basic school entrance, mandated health histories, means school-generated developmental health histories elicited at entrance to school (kindergarten or new enterers) and the most current grade required by the local district.

Specific health information questionnaires, i.e., asthma, allergy, diabetes, seizures, means questionnaire forms which are updated by parents to provide the school nurse with medical information specific to a health issue.

Nontransferable Forms (Remain in the District)

Access Sheets means a record indicating the date and the person or agency accessing the student's record.

Third-Party Records means records sent to an educational institution upon request of the school from an outside provider. These records may be, but are not limited to, medical records and evaluations, psychological evaluations and reports, as well as any other information. These third-party records cannot be transferred to the new district without written parental permission. A notation should be made on the CHR stating that third party information was received, including the date of the report and the provider name. Please note that any information regarding the HIV/AIDS status cannot be recorded on the CHR and without proper consent information should be returned to the sender according CGS 19a-583. Medical records or evaluations completed by the medical advisor or psychiatrist employed by the district or as the result of an evaluation at the expense of the school are not considered third-party reports.

Release of information forms (includes letters from lawyers) means specific release form that the parent/guardian or student (if not a minor) has signed granting the school permission to communicate confidential information either verbally or in writing with an outside provider. A notation should be made on the CHR that the release was obtained and the requested information has been sent or received.

Previous IHCP/ECP – see definition.

Miscellaneous health care provider and parent notes means notes received from parents and health care providers concerning a particular health concern (not as a follow-up to a school health referral). Any significant findings need to be summarized on the CHR.

Past health information questionnaires (past information sheets on asthma, seizures, etc.) – see definition.

Not to be kept in CHR at any time

Accident/Incident reports. These should be completed according to local board policy and should not be kept in the CHR. A nursing note, including nursing assessment, interventions and disposition, should be documented on the CHR.

Raw data from nursing health assessments of students with disabilities do not need to be retained once the nursing summary is written.

Controlled Substance Medication Records for Audits. In addition to documentation in the CHR, the individual medication administration sheets for controlled substances must be retained along with a copy of the medication order for three years. These records are stored in the school where the medication was administered and then can be destroyed.

Sole Possession Notes. These are records that are kept in the sole possession of the school nurse, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the school nurse.

Destruction of any records needs to be in accordance with the Connecticut Retention Schedule for Education Records (CGS 11-8a).

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